Kymriah

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the member identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-844-823-5477**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-800-469-7556.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________ **Date**: ________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** _________________________________
Physician Office Telephone: __________________ **Physician Office Fax:** ___________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ______________________________
Fax: _________________________ **Phone:** ______________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*__________________________*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-844-823-5477

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Criteria Questions:

1. What is the diagnosis?
   - ❑ Acute lymphoblastic leukemia (ALL)
   - ❑ Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma (also known as histologic transformation of follicular lymphoma to DLBCL)
   - ❑ Histologic transformation of nodal marginal zone lymphoma to DLBCL
   - ❑ Diffuse large B-cell lymphoma
   - ❑ Primary mediastinal large B-cell lymphoma
   - ❑ High-grade B-cell lymphoma (including high-grade B-cell lymphoma with translocations of MYC and BCL2 and/or BCL6 [double/triple hit lymphoma], high-grade B-cell lymphoma, not otherwise specified)
   - ❑ Acquired immunodeficiency syndrome (AIDS)-related B-cell lymphomas (including AIDS-related diffuse large B-cell lymphoma, primary effusion lymphoma, and human herpesvirus 8 (HHV8)-positive diffuse large B-cell lymphoma, not otherwise specific)
   - ❑ Monomorphic post-transplant lymphoproliferative disorder (B-cell type)
   - ❑ Other ____

2. What is the ICD-10 code? _____________

3. Has the patient previously received one complete treatment course of Kymriah or another CD19-directed chimeric antigen receptor (CAR) T-cell therapy (e.g., Yescarta)? ❑ Yes ❑ No

4. Does the patient have adequate and stable kidney, liver, pulmonary and cardiac function? ❑ Yes ❑ No

5. Does the patient have active or latent hepatitis B, active hepatitis C, or any active uncontrolled infection? ❑ Yes ❑ No

6. Does the patient have active graft versus host disease? ❑ Yes ❑ No

7. Does the patient have an active inflammatory disorder? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Acute Lymphoblastic Leukemia (ALL)

8. Does the patient have B-cell precursor acute lymphoblastic leukemia? ❑ Yes ❑ No

9. Does the patient have CD19 tumor expression in bone marrow or peripheral blood? ***ACTION REQUIRED: If Yes, attach results of testing or analysis confirming CD19 tumor expression in bone marrow or peripheral blood.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

10. Does the patient have at least 5% lymphoblasts in the bone marrow? ***ACTION REQUIRED: If Yes, attach results of testing or analysis confirming at least 5% lymphoblasts in the bone marrow.*** ❑ Yes ❑ No ❑ Unknown or testing has not been completed

11. What is the Philadelphia chromosome status for the patient's disease?
    - ❑ Philadelphia chromosome-positive disease
    - ❑ Philadelphia chromosome-negative disease
    - ❑ Unknown

12. Does the patient meet any of the following? ***ACTION REQUIRED: Attach chart notes, medical record documentation or claims history supporting previous lines of therapy.***
    - ❑ Patient has refractory disease
    - ❑ Patient has had 2 or more relapses
    - ❑ Patient has had 2 or more relapses AND has failed at least 2 tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib)
    - ❑ Patient has relapsed disease and is TKI intolerant
    - ❑ Patient has experienced a relapse post-hematopoietic stem cell transplant (HSCT)
    - ❑ None of the above

13. What is the patient's Karnofsky (age 16 years or older) or Lansky (age younger than 16 years) performance status? _______________%

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CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

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Section B: B-Cell Lymphomas

14. Has the patient received prior treatment with two or more lines of systemic therapy?
    ACTION REQUIRED: If Yes, attach chart notes, medical record documentation or claims history supporting previous lines of therapy. ❑ Yes ❑ No
15. Does the patient have primary central nervous system lymphoma? ❑ Yes ❑ No
16. Does the patient have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 2 (patient is ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours)? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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